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Statement

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Hearing on

Employment-Based Health Care Reform Proposals

by

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Statement Summary
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- Presently, 138.7 million Americans, 64 percent of those under age 65, receive health insurance through an employer- or union-sponsored plan.

- The cost of health benefits as a percentage of compensation for all workers has grown from 4.4 percent in 1980 to 6.3 percent in 1990. For employers who offered health benefits, the cost of those benefits were on average 10.9 percent of payroll.

- Health insurance costs in the private sector are not currently distributed equally among all payers. Ultimately the costs of employment-based health insurance are borne by employees, consumers, and taxpayers. The distribution of these costs depends upon the size of the employment-based group, the employer's market power in labor and output markets, and the demographics of the insured workforce.

- Small group reforms that institute community rating increase the costs for procuring health insurance for groups with relatively good risks while lowering insurance costs for relatively poor-risk groups.

- Requiring all employers to provide health benefits to workers and their dependents would decrease the number of uninsured from 36 million to 10 million.

- EBRI simulations estimated that between 200,000 and 1.2 million workers could become unemployed as a direct result of a mandate that employers provide health benefits to their employees.

- EBRI simulations estimated that an illustrative employer mandate would increase spending by employers on employer-sponsored health benefits by $33 billion to $86 billion, depending upon the cost of the mandated plan.

- EBRI simulations estimated that between 33 percent and 51 percent of all Americans would be enrolled in a public plan under an illustrative play-or-pay proposal if the payroll tax were set at 9 percent and all employers who had health benefit costs greater than 9 percent of payroll dropped their plans. The percentage of the previously uninsured who would gain coverage through an employment-based plan ranges from 43 percent to 78 percent.

- EBRI simulations estimated that such a proposal could increase employer spending by $45 billion overall, while employers with fewer than 25 employees would face increased costs of $18 billion.

- If wages and other components of total compensation could not adjust, some unemployment would result. EBRI analysis estimated that between 131,100 and 965,000 jobs could be lost under a play-or-pay proposal with a 9 percent payroll tax.

- The proportion of employers that would actually drop their health benefits if a play-or-pay proposal were enacted depends on a number of factors, most importantly the perceived quality of the public plan.

I am pleased to appear before you today to discuss employment-based health care reform proposals. My name is Bill Custer. I am the Director of Research at the Employee Benefit Research Institute (EBRI), a nonprofit, nonpartisan, public policy research organization based in Washington, DC. EBRI has long been committed to the accurate analysis of public policy employee benefit issues. Through our research, we strive to contribute to the formulation of effective and responsible health, welfare, and retirement policies. In keeping with EBRI's mission of providing objective and impartial analysis, our work does not contain recommendations.

◆ Introduction

Presently, 64 percent of Americans under age 65 receive health insurance through an employer- or union-sponsored plan (Employee Benefit Research Institute, 1992). For most of the 138.7 million nonelderly Americans with employment-based coverage, the level of benefits offered, the range of choices in providers, treatments, and sites of care are superior to any publicly provided benefits presently offered in the United States. An EBRI/Gallup survey conducted in December 1991 found that 73 percent of Americans with health benefits rated their health benefits as excellent or good.

The employer share of national health expenditures has remained virtually constant since 1980, but national expenditures for health have grown faster than income. As a result, health benefits as a percentage of compensation (averaged over all workers whether they receive health benefits or not) have grown from 4.4 percent in 1980 to 6.3 percent in 1990 (Bureau of Economic Analysis, 1992) (table 1). An A. Foster Higgins survey conducted in 1991 found that among employers who offered health benefits, the average health plan cost was 10.9 percent of payroll.[1] Spending on employer-sponsored health plans has tripled in the last decade. In 1980, spending on employer health care benefits totaled $64.8 billion. By 1990, those expenditures had almost tripled, reaching $186.2 billion (Levit, 1991).

[1] This survey is of predominantly medium- and large-sized employers.

Table 1
Total Employer Outlays for Group Health Insurance and Medicare Hospital Insurance, and Employer Health Spending as a Percentage of Total Compensation, 1960–1990

Year	Employer Spending on Private Health Insurance ($ billions)	Employer Spending on Medicare Hospital Insurance ($ billions)	Health Care as a Percentage of Total Compensation
1960	$ 3.4	$ 0.0	1.1%
1965	5.9	0.0	1.5
1970	12.1	2.3	2.3
1975	25.5	5.6	3.3
1980	61.0	11.6	4.4
1981	71.7	15.9	4.8
1982	82.6	16.8	5.2
1983	91.5	18.7	5.4
1984	100.3	20.6	5.4
1985	107.4	22.7	5.5
1986	113.7	26.1	5.5
1987	122.9	27.7	5.6
1988	138.7	29.6	5.8
1989	157.7	31.8	6.1
1990	174.2	33.6	6.3

Source: U.S. Department of Commerce, Bureau of Economic Analysis, *Survey of Current Business, January 1992* (Washington, DC: U.S. Government Printing Office, 1992); *The National Income and Product Accounts of the United States, 1929–82* (Washington, DC: U.S. Government Printing Office, 1986); and *The National Income and Products Accounts of the United States, Statistical Supplement 1959–1988*, vol. 2 (Washington, DC: U.S. Government Printing Office, 1992).

Health insurance costs in the private sector are not currently distributed equally among all payers. The cost of employer-sponsored health insurance depends on the characteristics of the employer's work force, risk factors attributed to the industry, and the employer's market power in the local health care services market. There are significant differences in health care costs across regions, industries, and between large and small employers.

Ultimately the costs of employment-based health insurance are borne by employees in the form of lower wages and salaries, lower levels of other benefits, and fewer jobs; by consumers in the form of higher prices for goods and services; and by taxpayers. The distribution of these costs depends on the relative market power of the employer in their input and output markets and their relative market power in the health care services market.

These considerations have led many to argue that tying the financing of health care to the labor market results in an inequitable distribution of both benefits and costs. The number of nonelderly Americans without health insurance has increased to 35.7 million.

Individuals without health insurance are predominantly nonworkers, self-employed, workers in small establishments, or persons in families headed by a member of one of these groups (table 2). These individuals face the highest costs of obtaining health insurance coverage, especially when those costs are calculated as a percentage of family income.

Table 2
Nonelderly Population with Selected Sources of Health Insurance, by Industry and Size of Family Head's Employer, 1990

Work Status and Firm Size of Family Head	Total	Total Private	Employer Provided			Other Private	Total Public	Medicaid	No Health Insurance Coverage
			Total	Direct	Indirect				
				in millions					
Total	215.9	158.3	138.7	70.3	68.4	19.7	29.2	21.6	35.7
Family Head Works	192.9	151.6	134.6	67.5	67.1	17.1	17.0	11.4	30.5
Under 25	49.7	31.8	22.5	11.0	11.4	9.3	5.3	3.8	14.0
25-99	25.2	18.5	16.8	8.4	8.3	1.8	2.5	1.9	5.0
100 or more	118.0	101.3	95.3	48.0	47.3	6.1	9.3	5.6	11.6
Family Head Does not Work	23.0	6.7	4.1	2.8	1.3	2.6	12.2	10.2	5.2
Self-Employed	17.6	12.7	7.7	3.4	4.3	5.0	1.2	0.7	4.1
Under 25	16.2	11.5	6.6	3.0	3.7	4.8	1.2	0.7	4.0
25-99	1.0	0.9	0.7	0.3	0.4	0.1	0.0	0.0	0.1
100 or more	0.4	0.4	0.3	0.1	0.2	0.1	0.0	0.0	0.0
Wage and Salary Workers	175.4	138.9	126.8	64.1	62.8	12.1	15.8	10.6	26.5
Under 25	33.5	20.3	15.8	8.1	7.8	4.5	4.1	3.2	10.0
25-99	24.3	17.7	16.0	8.1	7.9	1.7	2.4	1.9	4.9
100 or more	117.6	100.9	95.0	47.9	47.1	6.0	9.3	5.6	11.6
				(percentage within industry and firm size categories)					
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Family Head Works	89.3	95.8	97.0	96.1	98.1	86.8	58.2	52.8	85.4
Under 25	23.0	20.1	16.2	15.7	16.7	47.1	18.0	17.8	39.1
25-99	11.7	11.7	12.1	12.0	12.2	9.1	8.4	8.9	13.9
100 or more	54.6	64.0	68.7	68.3	69.1	30.9	31.8	25.8	32.5
Family Head Does not Work	10.6	4.2	3.0	3.9	2.0	13.0	41.8	47.5	14.5
Self-Employed	8.1	8.0	5.6	4.9	6.3	25.5	4.2	3.2	11.5
Under 25	7.5	7.3	4.8	4.2	5.4	24.6	4.0	3.1	11.1
25-99	0.4	0.5	0.5	0.5	0.6	0.6	0.1	0.1	0.2
100 or more	0.2	0.2	0.2	0.2	0.3	0.3	0.0	0.0	0.1
Wage and Salary Workers	81.2	87.7	91.5	91.2	91.8	61.5	54.0	49.3	74.0
Under 25	15.5	12.8	11.4	11.5	11.4	22.6	14.0	14.7	27.9
25-99	11.2	11.2	11.6	11.6	11.6	8.5	8.3	8.8	13.7
100 or more	54.4	63.8	68.5	68.1	68.9	30.5	31.7	25.8	32.4

Source: Employee Benefit Research Institute tabulations of the March 1991 Current Population Survey.
Note: Details may not add to totals because individuals may receive coverage from more than one source.

S. 2114 and S. 1227, as well as other proposals, incorporate two general approaches for expanding employment-based health insurance to those groups not presently covered. One is to lower the costs faced by these groups in an effort to encourage them to purchase health benefits. The other is to require that they purchase health insurance from either public or private plans. Both of these approaches redistribute the costs and the benefits of health care services.

◆ **Small Group Insurance Market Reform**

Small groups often face higher costs per participant because of their higher per capita administrative costs and insurance companies' limited ability to pool risks. By removing barriers that prevent insurers from pooling small groups, employment-based coverage may expand to include many of the employed uninsured in small firms and their dependents (who constitute 39 percent of the nonelderly uninsured).

Many proposals, including S. 1227, would impose community rating with limited adjustment allowed for age and sex differences. Some analysts argue that mandating community rating or eliminating demographic adjustments would raise rates for many groups and create adverse selection.

Adverse selection occurs when individuals with greater health risks are disproportionately enrolled in a particular plan. Community rating limits insurers' ability to charge different premiums to groups on the basis of risk because the premium charged under a community rating scheme would limit the risk factors used to determine the premium. As a result, premiums for groups that represent good health risks would rise with the implementation of community rating, while premiums for groups representing bad risks would fall. Some of the good risks would choose not to purchase health insurance as a result of the premium increase, while more of the bad risks would purchase health insurance. The result would be an increase in the pool's average risk, increasing premiums and potentially creating a vicious circle that would end with an unsustainable health insurance market. The likelihood of this scenario actually occurring depends on the sensitivity of the demand for health insurance to changes in premiums among good and bad risks as well as on the ability of individuals to determine their own risk status.

S. 1227 mandates that all Americans receive coverage through either a public or a private plan. In this case, community rating would increase the costs of insurance for

the good risk groups, providing them with a greater financial incentive to choose to enroll in the public plan. Conversely, poor risks would see their premiums decrease, making it more likely they retain private benefits than under experience rating. The net impact of these incentives will depend on several factors including the payroll tax rate, the local community rates, and the perceived quality of the public plans.

Another mechanism for preventing adverse selection is to reinsure the poor risk by direct subsidization through a state risk pool. A number of proposals include measures that would encourage the creation of either public or private reinsurance pools to reduce the effects of adverse selection. These pools would allow individual insurance plans to cap the costs of the poorer risks, permitting them to offer lower premiums than would otherwise be possible.

The development of reinsurance markets, or state risk pools to subsidize the insurance costs for poor risks may alleviate some concerns about restrictions on premiums. However, public and private reinsurance schemes distribute the cost burden differently. If a private reinsurance market develops, the costs of providing expanded access to poorer risks will be borne by the purchasers of insurance. The premium paid by individuals and employers for health coverage will include the premium paid by insurers for the reinsurance of poorer risks. On the other hand, the burden of the costs of a public risk pool will depend on the financing mechanism for that pool. Most state risk pools are now financed by state insurance premium taxes.

Researchers evaluating the Robert Wood Johnson Foundation (RWJF) projects for the medically uninsured found that small employers' primary reason for not offering health insurance was the high cost of coverage—85 percent of employers not offering insurance cited high premiums as an important reason (McLaughlin, 1991). Although the RWJF demonstration projects did not reform local small group insurance markets the way that current national proposals would, their goals are similar: to stabilize the cost of insurance to small businesses and distribute these costs more equitably. Previously uninsured small employers began to offer insurance to their employees during the enrollment phase of the demonstration projects. However, only 17 percent of employers who previously did not offer insurance enrolled even in the most successful RWJF project targeted at small employers (McLaughlin, 1991). If the experience of these projects is representative of national experience, small group insurance market reform by itself may result in a minority of small employers choosing to purchase health insurance.

◆ Employer Mandates

Requiring all employers to provide health benefits to workers and their dependents would decrease the number of uninsured from 36 million to 10 million (table 3). Because many of the uninsured work for small firms, exempting employers with fewer than 25 employees would only reduce the number of uninsured to about 25 million. This analysis assumes that there are no changes in employment as a result of a mandate, even though health benefits represent a significant component of total compensation (10.9 percent of payroll among employers who offer health benefits) (A. Foster Higgins & Co., 1992). Clearly, if a mandate were implemented without a transition period, so that other elements of total compensation (such as wages) could not adjust, the cost of labor would increase substantially, possibly causing some loss of jobs.

Table 3
Coverage Effects of an Illustrative Employer Mandate, 1990

	Present system	Number Covered under Small Exempt Mandate[a]	Number Covered under Universal Mandate[b]
	(millions)	(millions)	
Total	248.9	248.9	248.9
Private			
Direct employer	71.2	86.6	117.7
Indirect employer	68.7	75.3	71.4
Other private	19.5	13.9	5.4
Public			
Medicare	31.4	30.6	29.2
Medicaid	17.2	15.5	13.3
CHAMPUS[c]	4.8	1.8	1.0
Uninsured	36.0	24.6	10.3

Source: Employee Benefit Research Institute simulation using March 1991 Current Population Survey.
[a]The mandate requires all employers with 25 or more employees to provide health insurance to employees working 25 or more hours per week.
[b]The mandate requires all employers to provide health insurance to employees working more than 19 hours per week.
[c]The Civilian Health and Medical Program of the Uniformed Services.

EBRI simulated changes in employment that would occur as a result of mandating that all employers offer health benefits (wages and other elements of total compensation were held constant). The sensitivity of employer demand for workers to changes in the price of labor is crucial in this simulation. The EBRI analysis used a range of estimates of this sensitivity based on economic literature (Hamermesh, 1986). It should be noted that other values supported by the economic literature could be cited that would

increase or decrease the estimated employment effects by large amounts. The other crucial assumption used in this simulation was the costs of the mandated health benefits. Without specifying the actual component services that would be covered, separate EBRI simulations were conducted using different estimates of the average annual cost of health benefits per individual employee—$970, $1,450, and $2,430. The cost of each additional dependent was assumed to be 60 percent of the individual cost. Again, these estimates assume that wages and other benefits do not change as health benefits are added. Clearly, if wages adjust, fewer individuals would become unemployed as a result of a mandate..

EBRI's simulations estimated that between 200,000 and 1.2 million workers could become unemployed as a direct result of a mandate that employers provide health benefits to their employees. The higher estimates were the result of higher average costs of the mandated health plan and greater price sensitivity of the demand for labor.

EBRI analysis also found that the cost of an employer mandate would be borne primarily by small employers and their employees. EBRI estimated that an illustrative employer mandate would increase spending by employers on employer-sponsored health benefits by $33 billion to $86 billion. The wide range between the estimates is related to assumptions about health plan costs. If employers with fewer than 25 employees were exempt from the mandate, spending would increase by $12 billion to $33 billion. Costs for employer-sponsored health benefits would also be redistributed. Workers who had previously been covered under another employer's plan would now be covered directly under their own employer's plan. For example, under a mandate with an average health plan cost of $1,450 per individual employee and no employer size exemptions, about $20 billion in costs would be redistributed from one employer to another. About 45 percent of these transferred costs ($9 billion) would be redistributed to small employers. If small employers were exempt from the mandate, the total costs redistributed among all employers would be only about $5 billion.

The question of whether uninsured workers and their families would be better off if health insurance were extended to them under an mandate centers on the issue of whether they are uninsured by choice. Do workers select jobs that do not offer health benefits in order to receive higher levels of cash compensation or other benefits? If employees are choosing a total compensation package that does not include health benefits, any measure that forces them to accept a package with health benefits will make them worse off.

However, society may benefit by forcing individuals to purchase health insurance. Individuals who choose not to purchase health benefits are gambling that they will not need health care services. They may make that bet knowing that care will be available to them in the case of a catastrophic event. Thus, society may bear at least a part of the risk that the individual chose not to insure against.

An employer mandate is essentially a payroll tax, although the burden of that tax is not distributed equally across all employees, employers, or consumers. Some of the costs of mandated health benefits would be passed on to employees in the form of lower wages, lower levels of other noncash benefits, or unemployment. Low-income workers would have less opportunity to trade wages for health benefits and would be more likely to experience the effects of an employer mandate in the form of unemployment. Some of the costs might be passed on to consumers in the form of higher prices. The remainder of the costs of a mandate would be borne by the investors and owners of the firms subject to the mandate. The distribution of this burden would vary by industry, region, firm size, and ownership type.

◆ Play-or-Pay Employer Mandates

Play-or-pay proposals limit the costs that employers would face under an employer mandate by allowing employers to pay a payroll tax rather than provide health benefits. The revenue generated by the payroll tax would be used to at least partially fund a comprehensive public program.

Estimates of changes in health insurance coverage and costs of such a plan vary substantially, depending on the behavioral assumptions chosen. Simulations of these proposals must determine which employers will continue (or begin) to provide health insurance and which will instead pay the public plan to cover its employees. A recent study by the Urban Institute assumed that employers would base their choice of whether or not to participate in the plan on cost alone (Zedlewski, 1992). If their average per capita premium would be lower under the pay option, employers would enroll their workers in the public plan. The study analyzed both a 7 percent and a 9 percent payroll tax. It found that under the 9 percent tax scenario nearly 40 percent of nonelderly Americans would be enrolled in the public plan, and under the 7 percent scenario 52 percent would be enrolled in the public plan.

EBRI simulation of a play-or-pay mandate also made the assumption that employers whose actual or prospective health benefit costs were greater than the payroll tax would choose to enroll employees in the public plan rather than provide health benefits directly. Again, three different estimates of the average annual cost of health benefits per individual employee were used in the simulation—$970, $1,450, and $2,430. The cost of each additional dependent was assumed to be 60 percent of the individual cost. This simulation produced estimates which found that between 33 percent and 51 percent of all Americans would be enrolled in the new public plan if the payroll tax were set at 9 percent. The percentage of nonelderly enrolled in the public plan would range between 24 percent and 45 percent. The percentage of the previously uninsured who would gain coverage through an employment-based plan ranges from 43 percent to 78 percent. Of the new enrollees in the public plan, between 10 million and 45 million would have previously received benefits through an employer-sponsored health plan. The relative size of the public plan has important implications for the distribution of the costs of play-or-pay proposals.

Assuming that all employers whose health care costs were greater than 9 percent of payroll dropped their health benefits and paid the payroll tax (assuming a play-or-pay mandate with an average cost of $1,450 per employee), such a proposal could increase overall employer spending by approximately $45 billion. Employers with fewer than 25 employees would face increased costs of $18 billion.

If wages and other components of total compensation could not adjust, some unemployment would result. EBRI analysis estimated that between 131,100 and 965,000 jobs could be lost under a play-or-pay proposal with a 9 percent payroll tax. Again, as under an employer mandate, these estimates assume no transition period nor any adjustment in other components of total compensation. In practice, the impact on employment is likely to be lower than these estimates indicate.

The proportion of employers that would actually drop their health benefits if a play-or-pay proposal were enacted depends on a number of factors. If the public plan were considered inferior to private plans, employers might continue to offer private health benefits in order to gain a competitive advantage in the labor market. An employer's willingness to continue health benefits may depend on the characteristics of its local health care market. Employers that lack confidence in their ability to manage their health care costs may be more likely to drop health benefits. Conversely, if the public

plan attracted a large proportion of poor health risks, the cost of private insurance may fall, prompting many employers to continue to offer health benefits. The characteristics of the public plan are, therefore, the most important determinant of the willingness of employers to drop their health benefits.

S.1227 requires that the new public program offer the same benefits as mandated of private plans. Providers would be reimbursed at levels at least equivalent to Medicare reimbursement rules. Although states would receive a federal matching grant, they would administer the program and eventually assume an increased funding role. Given the state and federal budget constraints it seems unlikely that real provider income from AmeriCare would match that available from some private plans. The public plan's ability to set fees and monitor utilization and the pressures of politically determined budgets would likely decrease most providers' income. The reduced number of private plans, coupled with employers' willingness to drop health benefits as costs increase, would limit cost-shifting to the private sector.

These factors coupled with employers' desire to offer benefits that attract and retain a skilled workforce, may mean that many employers would continue to offer health benefits even if the costs of such benefits as a percentage of payroll exceeded the payroll tax. This would especially be true if the perceived quality of care in the public plan was inferior to the quality of care received by privately insured patients.

Conversely, limits on provider revenues may reduce the number of providers, their ability to invest in technological innovation, and their ability to finance health care services research. It is unclear how this would affect the quality of care in the short run. Many argue that the United States has overinvested in health care technology and overtrained physicians. A reduction in expenditures for these purposes may free resources needed to finance care for those who have faced access barriers in the past. However, in the long-run there may be less innovation in health care and fewer of the best and the brightest entering the medical profession.

The absence of national health care reform does not imply a static health care delivery system. Public and private purchasers are independently developing and implementing cost management strategies that could potentially have profound effects on the cost, access, and quality of health care services. Changes in the way that Medicare reimburses physicians, which began to be implemented in 1992, may alter the willingness of physicians of different specialties to accept Medicare patients and thus

alter the type of treatment available. Both public and private payers are refining and implementing utilization management procedures that may alter incentives to providers and consumers. Private payers are beginning to selectively contract with providers in the hope of encouraging cost-effective practice styles. While these changes have the potential to reduce the rate of health care cost inflation, they may also segment the market, further differentiating the care received by those with private health insurance, beneficiaries of public programs, and the uninsured.